OVERSEAS REPORT

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La drogue à Paris, 1974

One of the minor (or perhaps major) evidences of the speed with which things change in our world nowadays is the rapidity with which fashions in the abuse (sorry, nonmedical use) of drugs change. For example, we learn from an interview with a Parisian authority on drug addiction, Dr. C. Olievenstein (*Concours Med* 96: 2313, 1974), that in Paris, trendsetter in some fashions, abuse of heroin has declined in 1973 although more heroin addicts have died. He should know because he runs a drug abuse centre at a leading Paris hospital, and he explains the paradox by the fact that most of the heroin no longer comes from Marseilles, where it used to be cut with inert substances so as to contain only 2 to 5% of heroin, but now arrives from efficient Dutch distributors in Amsterdam and has at least 33% of narcotic. However, in 1973 only 45% of his clientele were on narcotics and only 20% on heroin. The other drugs mostly come from raids on pharmacies (two a week in Paris), so that, for example, pure cocaine has reappeared on the market there. Two other sources are the naïve doctor conned into prescribing drugs for a suffering addict, and the enormous sale of cough remedies containing codeine. The partial ban on amphetamines had the unwanted effect of driving some amphetamine fanciers to the use of heroin; meanwhile there is an upsurge in abuse of some nonamphetaminic anorexiants.

Apart from hard drugs, a serious problem is the juvenile raid on family drug cupboards, which are apt to contain sizable amounts of barbiturates, tranquillizers or sedatives. The result is an increase in serious self-poisoning episodes. A solution is hard to envisage, since these drugs have a wide and legitimate field of use. Maybe the solution lies with education of parents, pharmacies and the pharmaceutical industry.

Olievenstein notes the rapid rise in the number of physicians with a special knowledge of drug addiction; there used to be three, now there are 70 in Paris; they are needed to cope with the increase in clients, who come voluntarily to the centre in search of information, in search of stocks of drugs, in search of a way out of their mess, or because they have reached a crisis or can no longer afford the cost of their drugs. One way of affording the drugs is, as everywhere, to commit violent crimes, the number of which has multiplied in Paris recently.

He notes that the efforts of the authorities to put out information on drug abuse in 1971 and 1972 show clearly in the drop in figures among adolescents reached in those years. Then the effort stopped, so now the children of 14, 15 or 16 who were not reached by the effort are being recruited into the ranks of the addicts. The drug scene has changed; the young victims now have their own apartments and their closed circles, so that their habits are much less conspicuous and parents and teachers are unlikely to know about these activities. Moreover, the term "adolescent" has changed; adolescence can be prolonged into the late twenties nowadays through failure to mature. Olievenstein refers to two current "racisms", the anti-youth racism and also the anti-older-generation racism, which prevents dialogue between the generations. This has nothing to do with social status or parental permissiveness, or with broken homes. Any family can get involved. But one interesting phenomenon is taking place in France. A few years ago the young detested alcohol simply because it was the parental drug; now the young are becoming alcoholics more and more, and this trend is quite serious. One special French problem is that of the African immigrant child, between two worlds, emerging from the slums but not accepted by French society and resenting this bitterly (there is no colour bar in France, but mankind is the same all over, alas). Says Olievenstein "We are not yet in the New York situation but there is a real risk of this". He sees the situation as very grave. The authorities persist in focusing attention only on narcotics, and the drug abusers are well organized now. And what about marijuana? As a physician, Olievenstein is not gravely concerned about this drug, but as a citizen he is, because of the unhealthy atmosphere surrounding its abuse, and the fact that the adolescent who uses it regularly has problems that need solving,. problems more important than his drug use.

Meanwhile teams like that of this author pursue their ungrateful task, trying to combine idealism with very necessary realism. They are in some respects the oncologists of the mind, treating its cancers.

Prenatal diagnosis of CNS malformations

A stop could be put to all the arguments about treatment or nontreatment of spina bifida cases if only we had a reliable test for the con-

dition that could be applied in early pregnancy, so that mothers destined to give birth to a spina bifida child (or an anencephalic) could be aborted.

Previous reports from Britain have indicated that the estimation of α-fetoprotein levels in either maternal serum during pregnancy or amniotic fluid might give a practical clue to these anomalies. There are obstacles, one being the need to lay down globally acceptable standards for normal levels of this protein at different stages of pregnancy. Another is the use of a variety of techniques giving different ranges of values, while a third is the cost of these techniques (see *N Engl J Med* 290: 568, 1974 for a discussion of this point).

The latest reports on the practical use of the test come from Edinburgh and Oxford and give us a little more hope for the future (N. J. Wald *et al*: *Lancet* I: 765, 1974 and D. J. H. Brock *et al*: *Ibid*, p 767). In Oxford, where a large scale survey of the outcome of pregnancy has been in progress for a year, sera taken antenatally have been stored routinely. Thus Wald *et al* were able to estimate α-fetoprotein in samples of stored sera after seven women had given birth to infants with spina bifida or anencephaly, and compare levels with those in 14 matched controls. In each affected case the level was higher than in the two matched controls. The α-fetoprotein level remained high throughout the four pregnancies resulting in a liveborn infant with spina bifida or anencephaly, but fell in the three pregnancies resulting in a stillbirth. Normally the level rises to a peak at 30 weeks and then falls. Results show that it may be possible to diagnose both conditions from the AFP level in early pregnancy, but not to say with complete confidence that a fetus is not affected.

The other paper records similar results. Brock *et al* in an Edinburgh series found that AFP values in maternal serum were above the normal range in all of eight cases of anencephaly and three out of five cases of spina bifida. They note that there is no correspondence between open lesions and abnormal values, and also that in two cases in which blood had been taken in time for a therapeutic abortion the plasma AFP values indicated central nervous system abnormality. The tragedy is that at present results are more clear-cut in cases of anencephaly than in spina bifida.

It is unrewarding to compare the merits of measurements in maternal serum and in amniotic fluid, since the purpose of the two examinations is different. One uses serum for a general screening test, and amniotic fluid only in cases where there is already a known risk of conception of a child with a CNS malformation. Even at a 10% level of efficacy (and the test is certainly better than that) serum estimations in all pregnancies would detect *in utero* before the 20th week the presence of at least 200 spina bifida cases in the United Kingdom each year.

Hazards of the search for health

We are all aware of the dangers of drugs and I have in my possession a German book of no less than 1000 pages on their side effects. But we forget that physical medicine is also not harmless; however, the side effects of physical measures are poorly understood and not often written about. A report by W. Teichmann of adverse effects of treatment at a German spa near Augsburg which handles only health insurance patients is worth while studying (*Dtsch Med Wochenschr* 99: 739, 1974)

In 15 years 32,113 patients passed through his spa, Bad Woerlshofen. Eleven (all men in the middle years) died, seven of a myocardial infarction. Three more became seriously ill during treatment and died in the local intensive care unit; one bled from an old duodenal ulcer, one bled from esophageal varices, and the third had a cerebral hemorrhage. The last of the 11 died suddenly while under treatment for chronic aggressive hepatitis. This incidence, says the author, is a lot better than that in spas that deal with more cardiac patients. Particularly vulnerable are men within two years of an infarction, especially if they have not been used to physical training or are older or have an intercurrent infection. Patients with chronic infections are also at risk.

Among the nonfatal incidents were seven fresh myocardial infarctions, but only one was obviously linked to demanding exercise. Four hemiplegias occurred, all in men around 60 years old, but another four had fleeting signs of cerebrovascular disorder. Three patients had a lung embolism, and 17 had disorders of cardiac rhythm associated with various physiotherapeutic measures. Ten patients collapsed in the bath house.

The second largest group of side effects after the circulatory ones were dermatological. They included eczemas, infection, allergic reactions and petechial rashes and appeared in 48 cases in direct association with some therapeutic modality. A third group consisted of menstrual disorders such as changes in cycle length or postmenopausal bleeding. Lastly there was a miscellaneous group including renal

colic, thromboses, and a flare-up of old infective foci. All told, the risks are very small in comparison with those of drug therapy.

Chocolate and migraine

Ever since I was a medical student I seem to have been hearing that patients with migraine should not eat chocolate. I have at times speculated on this peculiar association and wondered how much scientific basis there was to it. I have even at times pondered the possibility of collecting enough migraine sufferers together to test out in a double-blind trial whether the chocolate story was just one more medical myth. I can now stop worrying about it since someone has just done this for me.

Drs. A. M. Moffett *et al* of the London Hospital report the results of a double-blind trial using chocolate and a placebo made up for them by Cadbury-Schweppes (*J Neurol Neurosurg Psychiatry* 37: 445, 1974).

One should add that there is a possible rationale behind the chocolate story after all. Tyramine-containing foods can induce headache and EEG changes, and chocolate contains vasoactive amines and is often mentioned as a precipitating factor by migraine patients.

The London Hospital research workers advertised for volunteers among those who thought their migraine was precipitated by chocolate, and selected 25 aged 22 to 62 years (23 women, two men) for trial of the chocolate and the identical placebo; they were told it was just a different type of chocolate. They were asked to report whether either sample had caused a headache. A second trial with 15 subjects involved a different placebo compounded in the pharmacy of the hospital.

In the first study 15 headaches occurred after 50 sessions; eight followed consumption of chocolate and five consumption of the placebo. One subject had a headache after both and 11 had a headache after neither. In the second study 10 headaches followed 30 sessions; five were after chocolate and three after placebo, with again one subject sensitive to both and six sensitive to neither. Most of the subjects did not even give a consistent response in the two trials. The general lack of headaches after chocolate in persons who thought they were sensitive to it suggests that other factors were involved such as cheese, alcohol or citrus fruit, mentioned as other precipitants by some of the group.

The authors refer back to their earlier study showing that reports of precipitation of migraine by tyramine could not be confirmed either when this substance was presented to patients as a single factor (*N Neurol Neurosurg Psychiatry* 35: 496, 1974). It looks as if migraine does not result from a single factor such as chocolate, stress, tyramine or alcohol, but from a combination of these acting together on a susceptible individual.

Specialist discontent in Britain

Those who have been following the medicopolitical scene in the United Kingdom will be aware that, although general practitioners are on the whole not too discontented with their economic lot under the National Health Service, specialists are increasingly discontented and disillusioned. This is particularly the case outside London, and typical of the bitter feelings now having national repercussions are those expressed anonymously to a *British Medical Journal* correspondent and published in the BMJ of May 4, 1974 under the heading "Independence at Midwich".

Midwich is evidently a city in the Midlands, and one problem there is the poor quality of ancillary staff and the high turnover, together with the presence of large numbers of overseas staff of uneven quality. There are few applicants for specialist jobs nowadays, in contrast with the hordes of eager candidates as late as 10 years ago, so that a high proportion of immigrants has to be taken on, often with relatively unsatisfactory English; this means that they cannot engage in useful dialogue with patients.

The Midwich specialists were angry at the disparity between their earnings and those of younger men in family medicine, and thought that guerilla action by NHS specialists was quite on the cards. They had no confidence in the BMA as a negotiating body for them, and in fact it seems that most had resigned from it. Nor had they any confidence in the working party being set up by the ministry to revamp the specialist contract in the NHS. The possibility that private practice may be outlawed in Britain is now around the corner; if this happens, as the Midwich specialists pointed out, then the NHS will have to find a lot more money to make up for its loss.

Appropriately enough, on April 1 of this year the reformed NHS came into existence. Nobody seems to have been particularly aware of any change. No more money appeared, no more beds appeared, no more staff appeared. A *Lancet* correspondent (I: 798, 1974) puts it superbly: "Alas, no major cosmic phenomenon attended the birth of the new National Health Service. Graves did not yawn and yield up their dead... Worse, when we went to work on the morning of April 1, nothing seemed to have altered. The beds were still full, apart from those in wards closed for lack of nursing staff. The waiting lists were no shorter. The wards were as dingy as ever. For a while we tried convincing ourselves it was all some elaborate hoax..." But he found ominous portents, which he lists. "However, the expectation is that the new bureaucratic machine will function perfectly provided that it is not troubled by clinical doctors, nurses of Salmon grade 6 and below (these are the grades who would be giving direct care to patients) and, above all, patients." Mark these things well, my readers. For whom the bell tolls and so on.

Meanwhile, the quarrel between the BMA and some specialists continues. The BMJ of April 13 sadly records the unsuccessful attempt of the BMA specialist committee and the breakaway body, the Regional Hospitals' Consultants and Specialists Association, to resolve their differences about who represents the specialists *vis-à-vis* the government. The Regional Association has now made formal application to the Industrial Relations Court for recognition in NHS negotiations after 850 specialists formally resigned from the BMA. So who will gain?